°Private Providers
°Periodic Screening
°Vision and hearing
°Immunizations (see next claim)

°Paper billers only/split claim

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

| | |
|---|---|
| 1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID) — X | 1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 910000000K |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Bubble, Joey | 3. PATIENT'S BIRTH DATE MM DD YY: 08 01 97 SEX: M X F |
| 5. PATIENT'S ADDRESS (No., Street): 10 Bubblegum Road | 6. PATIENT RELATIONSHIP TO INSURED: Self Spouse Child Other |
| CITY: Raleigh STATE: NC | 8. PATIENT STATUS: Single Married Other; Employed Full-Time Student Part-Time Student |
| ZIP CODE: 27600 TELEPHONE (Include Area Code): ( 919) 555-1212 | |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) | 10. IS PATIENT'S CONDITION RELATED TO: |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER | a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO |
| b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F | b. AUTO ACCIDENT? PLACE (State) YES NO |
| c. EMPLOYER'S NAME OR SCHOOL NAME | c. OTHER ACCIDENT? YES NO |
| d. INSURANCE PLAN NAME OR PROGRAM NAME | 10d. RESERVED FOR LOCAL USE |

| | |
|---|---|
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) | |
| 7. INSURED'S ADDRESS (No., Street) | |
| CITY / STATE | |
| ZIP CODE / TELEPHONE (INCLUDE AREA CODE) ( ) | |
| 11. INSURED'S POLICY GROUP OR FECA NUMBER | |
| a. INSURED'S DATE OF BIRTH MM DD YY SEX M F | |
| b. EMPLOYER'S NAME OR SCHOOL NAME | |
| c. INSURANCE PLAN NAME OR PROGRAM NAME | |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, return to and complete item 9 a-d. | |

PATIENT AND INSURED INFORMATION

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

| | |
|---|---|
| 14. DATE OF CURRENT: MM DD YY — ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) | 15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY |
| 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY | |
| 17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE | 17a. I.D. NUMBER OF REFERRING PHYSICIAN |
| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY | |
| 19. RESERVED FOR LOCAL USE | 20. OUTSIDE LAB? YES NO $ CHARGES |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. V20.2 3. 2. 4. | 22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO. |
| | 23. PRIOR AUTHORIZATION NUMBER |

| 24 A DATE(S) OF SERVICE From MM DD YY | To MM DD YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 11 01 02 | 11 01 02 | 11 | | 99393 | EP | | 80 33 | 1 | | | | |
| 2 11 01 02 | 11 01 02 | 11 | | 99173 | | | 0 00 | 1 | | | | |
| 3 11 01 02 | 11 01 02 | 11 | | 92551 | | | 0 00 | 1 | | | | |
| 4 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

| | | | |
|---|---|---|---|
| 25. FEDERAL TAX I.D. NUMBER SSN EIN | 26. PATIENT'S ACCOUNT NO. | 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO | 28. TOTAL CHARGE $ 80 33 |
| 29. AMOUNT PAID $ | 30. BALANCE DUE $ 80 33 | | |

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

Signature on File

SIGNED _____ DATE 12/10/02

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

Cherry Healthcare
2000 Hubba Bubba Lane
Raleigh, NC 27600

PIN# 8900000 GRP# 8901000

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** APPROVED OMB-0938-0008 FORM CMS-1500 (12-90), FORM RRB-1500, APPROVED OMB-1215-0055 FORM OWCP-1500, APPROVED OMB-0720-0001 (CHAMPUS)